PRIOR APPROVAL

Services Requiring Prior Approval

Prior approval (PA) may be required for some services, procedures, or medical devices to verify medical necessity. PA is for medical approval only. However, PA must be obtained before rendering a service or procedure that requires prior approval. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

A recipient must be eligible for Medicaid coverage on the date the procedure is performed and must meet all medical necessity prior approval criteria. Retroactive PA is only considered when a recipient who does not have Medicaid coverage at the time of the procedure is later approved for Medicaid with a retroactive eligibility date.

Before admitting patients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit.

Unless a service is exempt from the Carolina ACCESS (CCNC) referral and authorization requirement, providers must obtain a referral authorization from the Carolina ACCESS (CCNC) enrollee's primary care provider in addition to requesting PA for any service or procedure that requires PA. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-11 for additional information.

Most requests for PA are submitted in writing to the EDS Prior Approval unit. However, requests for approval for services to recipients with a diagnosis of mental retardation may be faxed to EDS. Other services may be approved verbally and followed up with the written request. Requests for optical refractions are approved through the AVR system. Except in emergency situations, **all** services provided to Medicaid recipients by **out-of-state** providers must be approved prior to rendering the service. Refer to individual clinical coverage policies for specific instructions regarding prior approval (http://www.dhhs.state.nc/us/dma/mp/mpindex.htm).

Where applicable, PA forms should be completed and mailed to:

Prior Approval Unit
EDS
P.O. Box 31188
Raleigh, NC 27622

Refer to the following table for process for obtaining a PA by clinical service.

Service	Verbal Authorization	Written Authorization
Community Alternatives Program (CAP/AIDS, CAP/C, CAP/Choice, CAP/DA)	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval. This approval is for level of care only. Information must be from a completed N.C. Medicaid Program Long Term Care Services form (FL2) (372-124).	After receiving verbal approval, the completed N.C. Medicaid Program Long Term Care Services form (FL2) (372-124) must be received by EDS within 10 working days.
Dental		Complete a 2002 ADA claim form.

Service	Verbal Authorization	Written Authorization
Services		
Durable Medical Equipment	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval for emergency repairs to orthotic or prosthetic only.	Complete a Certificate of Medical Necessity and Prior Approval form Form 372-131(8/02).
Eye Examinations and Refractions	Call the AVR system at 1-800-723-4337 to receive verbal approval (or 1-800-688-6696 if the AVR system is not in service).	Complete a general Request for Prior Approval form (372-118) for medically necessary exceptions to the AVR system limitations.
Hearing Aids		Complete a general Request for Prior Approval form (372-118).
Hospice	Call 1-800-688-6696 or 1-919-851-8888 to report hospice benefit elections	
Intermediate Care/Mental Retardation Services	You may fax a copy of the N.C. Medicaid MR2 Mental Retardation Services form (372-123) to 1-919-233-6834. Effective September 1, 2005, forms should be faxed to 919-575-1083.	After receiving a faxed or verbal approval, the N.C. Medicaid MR2 Mental Retardation Services form (372-123) must be received by EDS within 10 working days. Effective September 1, 2005, forms must be submitted to the Murdoch Center within 10 working days and not to EDS.
Long-Term Care	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	After receiving verbal approval, the N.C. Medicaid Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 working days; or, submit an electronic FL2 through Provider Link.
MPW Recipients		Complete a general Request for Prior Approval form (372-118).
Out-of-State Non-Emergency Services	Call 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining Out-of-State approval. No authorizations can be granted verbally. All requests must be submitted in writing. The requests should be faxed to 1-919-233-6834.	Complete a general Request for Prior Approval form (372-118). A letter from the attending physician requesting Out-of-State services, indicating why the services cannot be done in North Carolina and medical records must accompany the prior approval form.
Outpatient Specialized Therapies		Fax a Prior Approval for Outpatient Specialized Therapies form and supporting documents to The Carolinas Center for Medical Excellence at 1-800-228-1437.
PCS-Plus	No verbal authorization option is available.	Complete a PCS-Plus Request Form (DMA 3000-A) and fax the form to 1-919-715-2628. The form is available at http://www.dhhs.state.nc.us/dma/forms.html#prov

Service	Verbal Authorization	Written Authorization
Prescription Drugs	Call ACS State Healthcare at 1-866-246-8505. Fax Pharmacy PA forms to 1-866-246-8507.	
Private Duty Nursing	Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated. The provider may call 1-919-855-4380 for PDN consultation.	Complete and fax a PDN Referral Form and a Physician's Request form which documents medical necessity to 1-919-715-9025. Note: forms are located at http://www.dhhs.state.nc.us/dma/forms.html#prov
Psychiatric Services, Inpatient (PRTF; Residential Child Care; Criterion #5; Out-of-State Residential Services)	Call Value Options at 1-888-510-1150.	
Psychiatric Services, Outpatient	Call Value Options at 1-888-510-1150.	
Out of State and State-to-State Ambulance Service	Call 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining Out of State and State-to-State Ambulance Services approval. No authorization can be granted verbally. All requests are reviewed in writing.	Complete a general Request for Prior Approval form (372-118). A completed and signed Out of State and State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the prior approval form.
Surgery	Call 1-800-723-4337 to verify if a surgery requires prior approval.	Complete a general Request for Prior Approval form (372-118). Include documentation supporting medical necessity.
Therapeutic Leave (over 15 consecutive days)	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	Follow up approval with a written general Request for Prior Approval form (372-118).

General Requests for Prior Approval

The Request for Prior Approval North Carolina Medicaid Program form (372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. Once a PA has been issued, it must be used within one year. The following services use this form:

- surgery
- out-of-state elective services
- services to Medicaid for Pregnant Women recipients
- hearing aid services
- therapeutic leave over 15 consecutive days
- out-of-state and state-to-state ambulance service

  Note: A completed and signed State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the PA request.
- additional eye exam/refraction services beyond AVRS limitations

Requests for Prior Approval of Out-of-State or State-to-State Ambulance Service

Prior approval is required for ambulance service by ground or air ambulance from North Carolina to another state, from one state to another, or from another state back to North Carolina. Prior approval for ambulance service is separate from prior approval for a medical procedure or treatment done out-of-state. Requests for PA must be submitted on the general Request for Prior Approval form (372-118) and the State-to-State Ambulance Transportation Addendum form (372-118A).

Requests for Prior Approval of Long-Term Care Services

The FL2 Long-Term Care Services form (372-124) is used by several programs for approval of long-term care nursing services. The following services use this form:

- out-of-state long-term care (nursing facility)
- in-state head injury rehabilitation
- long-term care nursing
- ventilator dependent care
- Community Alternatives Programs (CAP-AIDS, CAP-C, CAP-Choice, CAP-DA) for level of care determinations.

All electronic requests for long-term care nursing services must be submitted through Provider Link using the FL2e form.

Requests for Prior Approval of Services Provided to the Mentally Retarded

This MR2 Mental Retardation Services form (372-123) is used to assist in the review of services provided to mentally retarded clients. The initial review may be obtained by telephone or fax but a completed form must be submitted within 10 days of receiving verbal approval for final processing.

Requests for Approval of Optical Services

Requests for Routine Eye Exams and Refractions – Eye refractions do not require PA. However, it is in the best interest of the provider to obtain approval. If a second refraction is requested within the time

limitation period, a general Request for Prior Approval form (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to **Appendix A** for information about using the AVR system.

Requests for Prior Approval for Visual Aids – All visual aids require prior approval and requests must be submitted on a Request for Prior Approval for Visual Aids form (372-017). In some cases, this form must be accompanied by required documentation. Refer to the Optical Services Manual on DMA's website http://www.dhhs.state.nc.us/dma/optical.htm for information on services and limitations.

Requests for Prior Approval of Hearing Aids, FM systems, and Accessories

All hearing aids, FM systems, and accessories require prior approval. Requests must be submitted using the general Request for Prior Approval form (372-118) along with a letter from the physician or otologist stating medical necessity, the results of a hearing evaluation (to include audiogram), and the results of the hearing aid selection/evaluation tests.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also, in block 10, document the type of aid being requested (i.e., ANALOG PROGRAMMABLE, DIGITAL PROGRAMMABLE, OR FM SYSTEM).
- In block 12 document the reason(s) the recipient requires the requested system.

Requests for Prior Approval of Dental Services

Requests for PA for dental services are submitted using the 2002 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Services Policy/Provider Manual (#4A, Dental Services, and #4B, Orthodontic Services) on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. In order to easily access information submitted for PA, providers are encouraged to make a copy for their office records and note the date the PA was mailed.

Requests for Prior Approval for Durable Medical Equipment and Orthotic and Prosthetic Devices

Some durable medical equipment (DME) items and orthotic and prosthetic devices (O&P) require PA. In those cases, the Certificate of Medical Necessity/Prior Approval (CMN/PA) form must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the DME item is medically necessary to maintain or improve a recipient's medical, physical or functional level and to ensure that it is suitable and appropriate for use in the recipient's private residence or adult care home.

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to the **Clinical Coverage Policy #5A, Durable Medical Equipment** and **Clinical Coverage Policy #5B, Orthotic and Prosthetic Devices**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

Enhanced Care (Adult Care Home Recipients) Approval Process

The ACH staff or the recipient's case manager makes a referral request for enhanced care on behalf of the recipient to the local county department of social services (DSS) by sending in a copy of the latest FL2, the 3050R and other referral documents as necessary. The local DSS case manager does an independent assessment and approves the recipient for enhanced care services if appropriate. The case manager calls

this approval in to the fiscal agent and receives a service review number. The case manager then sends the resident and the provider a decision notice.

Hospice Participation

This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice providers must also notify EDS when hospice benefits are revoked, a patient is discharged or a patient transfers from one hospice facility to another. Hospice participation information may also be obtained using the AVR system for dates of service May 1, 2000 and after.

Refer to **Appendix A** for information about using the AVR system.

Utilization Review for Psychiatric Services

The Medicaid program contracts with Value Options to provide utilization review of acute inpatient/substance abuse hospital care for recipients through age 64, Psychiatric Residential Treatment Facilities (PRTF), Levels II through IV Residential Treatment Facilities (four beds or more), outpatient psychiatric services, and Criterion #5.

After the eighth visit, providers must obtain authorization from Value Options for continued outpatient mental health services for recipients over the age of 21. Value Options reviews and approves the requests based on medical necessity according to established criteria. Recipients under the age of 21 are allowed 26 unmanaged visits.

Copies of the PA form can be obtained by calling Value Options at 1-888-510-1150.

Refer to the **Enhanced Benefit Mental Health/Substance Abuse Services, September 2005 and January 2006** on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm for additional information.

Prior Approval for Outpatient Specialized Therapies

The Medicaid program contracts with The Carolinas Center for Medical Excellence (CCME) to perform the PA process for outpatient specialized therapies. PA is required for continued treatment after six unmanaged visits, per discipline, per provider type. The PA request should be made at approximately the second ($2^{nd)}$ or third ($3^{rd)}$ visit to allow sufficient time for processing.

A completed and signed **Prior Authorization Request for Outpatient Specialized Therapy Services Form** and supporting documents must be faxed to CCME at 1-800-228-1437 for treatment to be continued. If appropriate, MRNC will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form is available on CCME's website at http://www.thecarolinascenter.org/.

Once these limits have been reached, PA must again be requested for continued treatment.

Refer to **Clinical Coverage Policy #10A, Outpatient Specialized Therapies**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

Requesting Prior Approval for Prescription Drugs

The Medicaid program contracts with ACS State Healthcare to manage the PA process for the following prescribed drugs:

- Procrit, Epogen, Aranesp
- Neupogen
- OxyContin
- Growth hormones

- Provigil
- Celebrex, Bextra, Vioxx
- Botox, Myobloc

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by phone, fax, e-mail or mail. Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can dispense a 72-hour supply without PA.

Copies of the prescription PA forms may be obtained by calling ACS State Healthcare at 1-866-246-8505 or online at http://www.ncmedicaidpbm.com.

Six Prescription Override Requests

In 1982, the N.C. General Assembly established a limitation of six prescriptions per recipient per month. Exemption from this limitation is authorized by the Department of Health and Human Services "when the life of the patient would be threatened without additional care." Therefore, patients being treated for one of the conditions listed below can be exempted from the dispensing limitation if that action is deemed necessary by the primary prescribing physician.

- end-stage renal disease
- chemotherapy and radiation therapy for malignancy
- acute sickle cell disease
- hemophilia
- end-stage lung disease
- unstable diabetes
- terminal stage, any illness, or life-threatening, any illness

Physicians can request exemption from the dispensing limitation for those Medicaid patients who qualify by completing and signing a Six Prescription Limit Override form (DMA-3098) and sending the form to the pharmacy of record for the recipient. Physician assistants (PA's) and family nurse practitioners (FNPs) are also allowed to sign the form. This form negates the requirement to write the diagnosis on every prescription for the purpose of exempting recipients from the dispensing limitation.

The physician may mail or fax the form to the recipient's pharmacy of record or the recipient may be asked to give the form to the pharmacist when the prescriptions are filled. The form must be updated every six months to validate the recipients continued qualification for the six-prescription override.

In compliance with Medicaid rules, pharmacists are required to retain these forms on file for five years. To bill the Medicaid program for more than six prescriptions per month, pharmacists **must** keep this form on file in the pharmacy at all times.

Two categories of recipients are exempt from the dispensing limitation of six prescriptions per month due to participation in a specific program:

- recipients participating in the Community Alternatives Program (CAP)
- recipients who are less than 21 years of age are exempt under guidelines established through the Health Check Program and EPSDT

It is not necessary for a physician to complete a form to exempt these recipients from the dispensing limitation. The program information is incorporated into the eligibility files.

A copy of the **Six Prescription Limit Override form (DMA-3098)** is available on page 6-9 or on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

Procedures for Approval and Reimbursement of Transplants

When a hospital transplant team determines that a patient requires a transplant (solid organ or stem cell) all of the supporting documentation justifying the medical necessity for the procedure must be sent to the Clinical Policy and Programs section at DMA for pre approval **if Medicaid will be the primary payer.** Packets are to be faxed to the transplant nurse consultant at 1-919-715-0051 including of: **Section 11A through 11H of the clinical coverage policy and procedure manual (on DMA's Web site http://www.dhhs.state.nc.us/dma/prov.htm under the provider information section) lists the criteria for Medicaid covered transplants.**

Solid organ transplant packets:

- Letter from physician requesting transplant and summarizing clinical history
- All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, and EBV
- All diagnostic and procedure results
- Complete psych/social evaluation with documentation of post transplant care needs
- Psychiatric history will require a psychiatric evaluation
- History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens
- Other organ specific policy criteria (http://www.dhhs.state.nc.us/dma/mp/mpindex.htm)
- Additional clinical and/or documentation may be requested

Stem cell transplant packets:

- Letter from physician requesting transplant and summarizing clinical history
- Previous chemotherapy regimes and dates
- All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, and EBV
- All diagnostic and procedure results inclusive of bone marrow aspiration
- Complete psych/social evaluation with documentation of post transplant care needs
- Psychiatric history will require a psychiatric evaluation
- History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens
- Other disease specific policy criteria (http://www.dhhs.state.nc.us/dma/mp/mpindex.htm)
- Additional clinical and/or documentation may be requested

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure except when a recipient is later approved for Medicaid with a retroactive eligibility date. All clinical criteria must still be met.

Upon review of the documentation, the physician and the facility will receive a notification of approval or denial from the Clinical Policy and Programs section at DMA. DMA does not authorize transplants for enrollees who have Medicare or private insurance. In order for DMA to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the Medicare denial/payment with the request for coverage of the transplant, and the complete transplant evaluation packet. The packet is then reviewed for clinical criteria.

Sample of Six Prescription Limit Override Form

NORTH CAROLINA
MEDICAID PHARMACY PROGRAM

Six Prescription Limit Override Form

North Carolina Medicaid recipients are allowed only six prescriptions per month unless they have one of the diagnoses listed below. If the attending physician, physician assistant (PA) or family nurse practitioner (FNP) determines that a recipient is eligible for the override, he/she must check all diagnoses that apply, complete the rest of the form, and sign in his own handwriting.

[ ] Acute Sickle Cell Disease

[ ] Hemophilia

[ ] End Stage Lung Disease

[ ] End Stage Renal Disease

[ ] Unstable Diabetes

[ ] Chemotherapy or Radiation Therapy for Malignancy

[ ] Any Life Threatening Illness or Terminal Stage of Any Illness

Recipient's Name _____

Recipient's MID Number _____

Facility _____
(Fill out only if in nursing facility or adult care home)

Physician, PA, FNP _____
(Must PRINT and SIGN, name must be LEGIBLE)

Prescriber's DEA No. _____

Date _____

* THIS FORM MUST BE UPDATED EVERY SIX MONTHS IF THE RECIPIENT STILL QUALIFIES FOR THE SIX PRESCRIPTION OVERRIDE

* THIS IS THE ONLY ACCEPTED FORM AND MUST BE KEPT ON FILE IN THE PHARMACY AT ALL TIMES

THIS FORM MAY BE REPRODUCED

DMA 3098 (Revised 3/03)